U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 28 September 2004

CASE NO.: 2001-BLA-449

In the Matter of

RONNIE L. SMITH,
Claimant

v.

ELKAY MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard Stayton, Esq.,
For the Claimant

Mary Rich Maloy, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on August 27, 2000, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first claim for benefits on September 28, 1994. (Director's Exhibit ("DX") 25-1). The Department of Labor denied the claim, dated January 18, 1995, because the evidence failed to establish the elements of entitlement that Mr. Smith had coal workers' pneumoconiosis or was totally disabled due to pneumoconiosis. (DX 25-19). The Claimant did not appeal this decision.

The claimant filed his current claim for benefits on August 27, 2000. (DX 1). On November 16, 2000, the claim was approved by the Department of Labor because the evidence established the elements of entitlement that Mr. Smith had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. (DX 19). On November 17, 2000, the employer requested a hearing before an administrative law judge. On February 13, 2001, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on February 3, 2004.

Interim benefits were paid by the Black Lung Disability Trust Fund beginning November 1, 2000 and continuing to the present, in the amount of $750.00 per month. (DX 24).

On July 1, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1, 3-20,[2] Director's exhibits ("DX") 1-27, and Employer's exhibits ("EX") 1-28[3] were admitted into the record.

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] On August 30, 2004, the undersigned issued an Order Granting Employer's Request to Strike Claimant's Exhibit 2. As of the hearing date, the October 19, 2002 X-ray film was missing. The record remained open until July 30, 2004 for Claimant to either provide the X-ray film to Employer's counsel or to advise that the film is lost. Claimant's counsel advised Employer's counsel that the X-ray film could not be found. Employer's counsel submitted a request to strike claimant's exhibit 2.

[3] The X-ray report of Dr. Meyer included in Exhibit 26 was not admitted in the record, due to cumulative evidence. (TR 18-19). Employer's Exhibit 27 was admitted in part. Employer's Exhibit 27 includes reports by Drs. Castle, Hippensteel, Loudon and Rosenberg. Claimant's counsel objected to the admittance of Employer's Exhibit 27. Employer's Exhibit 27 was submitted after the 20-day deadline for submission of evidence. Employer's counsel explained that the reports were late because they reviewed the records of Dr. Bellam, which was submitted just prior to the 20-day deadline. (TR 20-21). The portion of each doctor's report which discusses Dr. Bellam's treatment records and the reporting doctor's own previous report is admitted. The review of any other matter or medical evidence in these reports is excluded.

In addition to the evidence presented at the hearing, Claimant and Employer submitted a closing brief post-hearing.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a material change in the claimant's condition?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 19 years. (Hearing Transcript (TR) 19, DX 2, 3 and 25-19).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on August 27, 2000. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[4]

Elkay Mining Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F, Part 725 of the Regulations. (DX 3).

D. Dependents[5]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Doris Smith. (DX 1, 6; TR 7).

[4] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.
[5] See 20 C.F.R. §§ 725.204-725.211.

E. Personal, Employment and Smoking History[6]

The claimant was born on May 29, 1941. (DX 1). He married Doris Smith (Knipp), on December 28, 1959. (DX 1, 6). The Claimant's last position in the coal mines was that of a shuttle car operator. (TR 7). Towards the end of his employment, Claimant also worked outside the mine as a welder and a mechanic. Claimant testified that his job involved lifting anywhere from one pound to one hundred pounds everyday. He also stated that he was exposed to coal dust on a daily basis. Claimant stated that he stopped working in the mines when he was laid off in 1996. He testified that he could not obtain other employment. (TR 8-9).

Claimant testified that he was awarded Social Security Disability Benefits due to his lung problems. (TR 9).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. Claimant testified that he is a current smoker and smokes ½ to one pack of cigarettes per day. Claimant began smoking at age 19.

II. Medical Evidence

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[7]

There were 39 readings of six X-rays, taken on November 18, 1994, May 30, 2000, November 29, 2000, October 7, 2001, October 19, 2002 and April 23, 2003. (DX 15, 16, 21, 22, 23; EX 1, 2, 4, 6, 7, 11, 13, 14, 15, 16, 21, 22, 26; CX 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13).[8] Fifteen are positive, by physicians who are either Board-certified in radiology, B-readers or both.[9] Twenty-four are negative, by physicians whom are either B-readers, Board-certified in radiology, or both. A summary of the evidence is attached as Appendix A.

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[6] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[7] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[8] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[9] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

On February 11, 2002, Dr. Jerome Wiot was deposed by the Employer. Dr. Wiot is a Board-certified radiologist and a professor of radiology. He was previously the professor and chairman of radiology at the University of Cincinnati and director of radiology at the University of Cincinnati Hospitals, Cincinnati Children's Hospital and Cincinnati Veterans' Administration Hospital. Dr. Wiot was a member of the task force that put together the original B reader exam. (EX 17, pp.4-5).

Dr. Wiot detailed what needs to be seen on a chest X-ray to diagnose coal workers' pneumoconiosis. Dr. Wiot stated:

> Well, coal workers' pneumoconiosis is manifested radiographically by the presence of small, rounded and sometimes irregular opacities, which tend to begin in the upper lung fields. The more often, interestingly enough, they early occur in the right upper lung field rather than the left. These rounded or irregular opacities are more often what we call a q size, which is a part of the classification system, but, you know, you can have p's and r's, but more often q size opacities of coal workers' pneumoconiosis and sometimes t's.
>
> This process, as I say, begins in the upper lung fields, more often on the right than on the left. If the disease process becomes more severe, it will progress down the lung, so it goes down the chest rather than up.

(EX 17, pp.18-19). Dr. Wiot testified that it is his practice to give the benefit of the doubt to the patient in finding coal workers' pneumoconiosis. (EX 17, p.21).

Dr. Wiot read X-ray films of Mr. Smith, dated November 18, 1994, May 30, 2000 and November 29, 2000. He testified that none of these films show any evidence of coal workers' pneumoconiosis. Dr. Wiot found that the November 29, 2000 and May 30, 2000 X-rays show evidence of emphysema. He further stated that none of the abnormalities found on the chest X-rays relate to coal dust exposure. (EX 17, pp.22-24).

Dr. Wiot referred, in this reports, to nipple shadows seen on the X-ray. He explained that nipple shadows are shadows which appear from the breast nipple pressing against the X-ray cassette. He stated that such shadows are easy to recognize and very common. (EX 17, p.24).

B. Pulmonary Function Studies[10]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

[10] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehen-sion** **Cooperation**	**Qualify *** **Conform **** 	**Dr.'s Impression**
Dr. Zaldivar 4/23/2003 EX 21	61 73'	2.15		3.33	Yes		No Yes	Invalid spirometry due to poor effort.
Dr. Zaldivar 4/23/2003 EX 21 Post-bron	61 73'	2.28		4.54	Yes		Yes[11] Yes	Invalid spirometry due to poor effort.
Dr. Baker 10/19/2002 CX 1	61 72 ¼'	1.99		4.52	Yes	Good Fair	Yes[12] Yes	
Dr. Bellam 10/5/2001 CX 13	60 73'	1.72	56.1	3.43	Yes		Yes Yes	
Dr. Bellam 10/5/2001 CX 13 Post-Bron	60 73'	2.01	67.8	3.92	Yes		Yes Yes	
Dr. Zaldivar 11/29/2000 DX 23	59 73'	2.62	99	4.58	Yes		No Yes	

[11] The FEV1/FVC ratio equals 50.2%.
[12] The FEV1/FVC ratio equals 44%.

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehen-sion** **Cooperation**	**Qualify *** **Conform ****	**Dr.'s Impression**
Dr. Zaldivar 11/29/2000 DX 23 Post-Bron	59 73'	2.84	102	5.39	Yes		Yes[13] Yes	
Dr. Ranavaya 5/30/2000 DX 9	59 72'	2.02		2.62	Yes	Good Good	Yes Yes	Mr. Smith had a presyncopal episode (almost passed out) during exhalation and declined further testing.

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

On October 22, 2001, Dr. Dahhan, who is a B-reader and Board-certified in internal medicine and pulmonary medicine, submitted a review of the May 30, 2000 pulmonary function study performed by Dr. Ranavaya's office. Dr. Dahhan concluded that the study is invalid since it consists of only one FVC maneuver with premature determination of exhalation after only two seconds had lapsed. The patient declined further testing after having a pre-syncopal episode and almost passing out during exhalation. Dr. Dahhan opined that the study cannot be used to assess Mr. Smith's true ventilatory capacity or determine any respiratory impairment. (EX 10).

[13] The FEV1/FVC ratio equals 52.6%.

On October 9, 2001, Dr. Renn, who is a B-reader and Board-certified in internal medicine with a subspecialty in pulmonary medicine, submitted a review of the May 30, 2000 pulmonary function study performed by Dr. Ranavaya's office. (EX 12). The following are the eight reasons listed by Dr. Renn in determining that the study is invalid:

1. The source of the reference values has not been indicated on the report.
2. Race was apparently not considered in the calculation of predicted values.
3. Failure to maintain maximal effort throughout the entire FVC maneuver. The effect resultant from this is underestimation of the FEV1.
4. Failure to maintain the FVC maneuver for the requisite six seconds (10 seconds is optimal) and to plateau of one second duration defined as the minimal detectable volume of the spirometer. The effect resultant from this is underestimation of the FVC.
5. Failure to maintain the FVC maneuver beyond six seconds, a satisfactory plateau not having been reached during the initial six seconds. The effect resultant from this is underestimation of the FVC.
6. No satisfactory end-of-test attained from the FVC maneuver.
7. There were no, rather than the requisite three, satisfactory FVC maneuvers performed.
8. The practical limit of eight FVC maneuvers was not provided to result in three acceptable studies.

(EX 12).

On January 21, 2003, Dr. Renn submitted a review of the October 19, 2002 pulmonary function study. Dr. Renn determined this study to also be invalid. Dr. Renn determined there was a failure to maintain maximal effort throughout the entire FVC maneuver. He also found an unsatisfactory start of expiration. Dr. Renn stated that there were no satisfactory FVC maneuvers performed. Furthermore, he stated that the "practical limit of eight FVC maneuvers was not provided to result in three acceptable studies." (EX 20).

On July 25, 2000, Dr. Gaziano, who is a B-reader and Board-certified in internal medicine and chest disease, reviewed the May 30, 2000 pulmonary function study. Dr. Gaziano determined that the vents are not acceptable. He stated that there are an insufficient number of FVC, FEV1 or MVV tracings without explanation of deficiency. (DX 10).

For a miner of the claimant's height of 72 3/4 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.26 for a male 61 years of age.[14] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.88 or an MVV equal to or less than 90; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test.

[14] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 72 3/4" here, his average reported height.

Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
73	61	2.29	2.92	92
72 1/4	61	2.23	2.84	89
73	60	2.31	2.93	92
73	59	2.33	2.95	93
72	59	2.23	89	2.83

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
4/23/2003 EX 21	Dr. Zaldivar	39	82	No	
4/23/2003 EX 21	Dr. Zaldivar	38	75	No	
10/19/2002 CX 1	Dr. Baker	37	70	No	An exercise portion of this study was medically contraindicated due to shortness of breath.
11/29/2000 DX 23	Dr. Zaldivar	34	84	No	
11/29/2000	Dr. Zaldivar	35*	76*	No	Exercise stopped due to leg fatigue.

DX 23					
5/30/2000 DX 13	Dr. Ranavaya	35.2	62.9	Yes	
5/30/2000 DX 13	Dr. Ranavaya	41.2*	83.8*	No	

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respirator or cardiac illness."

Dr. Gaziano, who is a B-reader and Board-certified in internal medicine and chest disease, reviewed the May 30, 2000 arterial blood gas. Dr. Gaziano determined the test is technically acceptable. (DX 14).

D. Physicians' Reports and Depositions

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Robert G. Loudon is a professor of internal medicine and has served on the editorial board of the American Review of Respiratory Diseases. He is also a member of the American College of Chest Physicians.[15] (EX 5). He prepared a consultation report, based upon his review of the medical records of the claimant, dated May 16, 2001. Dr. Loudon reviewed medical examinations by Dr. Ranavaya, dated November 18, 1994 and May 30, 2000, and by Dr. Zaldivar, dated November 29, 2000. Dr. Loudon noted the work history and smoking history recorded by Drs. Ranavaya and Zaldivar. Dr. Loudon also reviewed questionnaires answered by the Claimant. Based on his review of the medical evidence provided to him, Dr. Loudon concluded there is not sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He found that Mr. Smith has a mild degree of pulmonary or respiratory impairment, which Dr. Loudon attributed to his smoking habit. He did not find that Mr. Smith is disabled from returning to his regular coal mining work. (EX 5).

Dr. Loudon submitted a second consultation report, based on his review of the Claimant's medical records, dated July 25, 2003. His report notes 18 years of coal mine employment, 16 of those years underground. He noted that the claimant began smoking in 1959 and is a current smoker, at a half to two packs per day. (EX 23).

After reviewing the medical records, Dr. Loudon concluded that there is not sufficient evidence to justify a diagnosis of coal workers' pneumoconiosis in Mr. Smith's case. Dr. Loudon did find a mild degree of pulmonary or respiratory impairment, due to Claimant's cigarette smoking habit. He did not find Mr. Smith to be totally disabled. (EX 23).

On June 29, 2004, Dr. Loudon submitted a supplemental report after reviewing Dr. Bellam's medical and laboratory records. Dr. Bellam's conclusions did not alter Dr. Loudon's conclusion that Mr. Smith does not have coal workers' pneumoconiosis. (EX 27).

Dr. Zaldivar is a B-reader and Board-certified in pulmonary diseases, internal medicine, and sleep disorder and critical care medicine. Dr. Zaldivar submitted an examination report, dated December 18, 2002, based on his medical examination of the Claimant, on November 29, 2000, and his review of Claimant's medical records. (DX 23). Dr. Zaldivar noted that Claimant worked in the mines for 21 years. He also noted a 40 year smoking history of a half a pack to three packs of cigarettes per day. Dr. Zaldivar described Mr. Smith's chief complaint as shortness of breath. Claimant communicated to Dr. Zaldivar that he has been short of breath for

[15] Employer's Pre-Hearing Report notes that Dr. Loudon has the British equivalent of Board-certification in internal medicine and pulmonary diseases.

about 15 years and wheezing has been present for several years. Claimant also stated that he has a daily cough productive of some white sputum. (DX 23).

Dr. Zaldivar concluded that there is evidence of coal workers' pneumoconiosis and chronic dust disease of the lungs. He also found a pulmonary impairment. He concluded, however, that the pulmonary impairment present would allow Mr. Smith to continue to perform his usual coal mining work or work requiring similar exertion. Dr. Zaldivar explained: "The pulmonary impairment present is not entirely the result of coal workers' pneumoconiosis. In fact, the major part of the impairment is due to emphysema caused by his life-long history of smoking and on-going smoking habit. The coal workers' pneumoconiosis present is participating in this airway obstruction, but not contributing to the same extent that the smoking is." (DX 23).

On July 31, 2001, Dr. George L. Zaldivar was deposed by Employer's counsel. Dr. Zaldivar examined Mr. Smith on November 29, 2000 and noted a twenty-one year coal mine employment history. Dr. Zaldivar characterized Claimant's mining work as light work at times to heavy work in spurts, depending on what he had to handle. (EX 8, p.5).

Dr. Zaldivar noted Claimant's smoking history as starting at age 18 and smoking 2 ½ to 3 packs per day. Dr. Zaldivar characterized this as very heaving smoking, for a long time. Dr. Zaldivar testified that such a smoking history would have been sufficient to cause very severe crippling emphysema, obstructive bronchitis. (EX 8, pp.5-6).

Dr. Zaldivar testified, with regard to Mr. Smith's November 29, 2000 physical examination, that Mr. Smith did not have any abnormalities that he would specifically attribute to coal workers' pneumoconiosis or coal mine dust induced lung disease. (EX 8, p.7). He stated that the pulmonary function study showed a moderate airway obstruction. Dr. Zaldivar did not find any improvement after bronchodilators were administered. He explained that this would put Mr. Smith in the category of emphysema, rather than asthma. Dr. Zaldivar also found a moderate degree of air trapping, consistent with emphysema. (EX 8, p.8). Dr. Zaldivar also found a mild reduction of the diffusing capacity, meaning the capillary beds of the lungs have been damaged as the lung is destroyed by the emphysema. Dr. Zaldivar opined that "cigarette smoking has pretty much cased all of his emphysema." He further stated that even if Mr. Smith had never worked in the coal mines, he would have as much disease or even more disease with his smoking history. (EX 8, p.9).

Dr. Zaldivar explained that smoking destroys lung tissue causing emphysema. He further stated that as the tissue destruction progresses, the capillary beds are destroyed, and that causes the diffusing capacity to be reduced. He explained that sometimes this can be seen in an X-ray as bullae, large holes in the lungs. Dr. Zaldivar stated that coal dust exposure does not cause any sort of bullae. Dr. Zaldivar classified Mr. Smith's X-rays as showing emphysema with over-distention. He testified that by the time a chest X-ray shows abnormalities, the individual has quite significant emphysema. He stated that in Mr. Smith's case, the emphysema can be seen radiographically. In addition, Dr. Zaldivar found a small amount of dust in the lungs, which could be related to coal dust exposure. (EX 8, pp.11-12).

Dr. Zaldivar testified that Mr. Smith's arterial blood gas studies show "that in spite of having moderate obstruction and emphysema, he has the capacity to do his work." The claimant

requested to stop the exercise study due to leg fatigue. (EX 8, p.14). Dr. Zaldivar noted that the arterial blood gas performed by Dr. Ranavaya also produced normal results. Dr. Zaldivar concluded, that at the time he examined Mr. Smith, the claimant did not have a totally disabling respiratory impairment. (EX 8, p.20).

Dr. George Zaldivar examined the claimant for a second time on April 23, 2003. His report, dated May 22, 20003, discusses the exam and his review of the Claimant's medical records. Dr. Zaldivar described the claimant's symptoms as shortness of breath for 10 to 12 years, wheezing and chronic cough productive of white sputum on a daily basis. (EX 21).

Dr. Zaldivar stated that the breathing test during the April 23, 2003 examination is invalid due to poor effort. He also stated that the high background of carbon monoxide in Mr. Smith's blood invalidated the diffusion capacity test. Mr. Smith stopped the exercise test due to a subjective complaint of shortness of breath, which Dr. Zaldivar stated was not supported by physiological findings. Dr. Zaldivar concluded that the chest X-ray showed small bullae scattered throughout the lungs. He explained that the bullae are a result of emphysema. Dr. Zaldivar suggested a CT scan to determine whether pneumoconiosis is present or not. (EX 21).

In conclusion, Dr. Zaldivar stated "there is radiographic evidence of pneumoconiosis or at least abnormalities radiographically which do resemble pneumoconiosis but may be due to other causes such as a smoker's bronchiolitis, as well as the known emphysema with the small bullae." Dr. Zaldivar found a mild pulmonary impairment. He also concluded that Mr. Smith, from a pulmonary standpoint, is fully capable of performing his usual coal mining work. (EX 21).

On June 28, 2004, Dr. Zaldivar was deposed a second time by Employer's counsel. (EX 28). Dr. Zaldivar testified that he examined the claimant in 2000 and 2003. He concluded that Mr. Smith had radiographic evidence of pneumoconiosis. Dr. Zaldivar performed pulmonary function studies at each examination, which he concluded are invalid due to inadequate effort. Dr. Zaldivar stated that the diffusing capacity results are invalid because Mr. Smith is a smoker. He stated that the blood gas studies showed a normal response. (EX 28, pp.5-7).

Dr. Zaldivar found a mild pulmonary impairment that he said was of "no significance." In discussing the pulmonary impairment, Dr. Zaldivar testified:

> Well, radiographically, he appeared to have coal workers' pneumoconiosis. I also mentioned that he did have bullae. This has something to do with coal workers' emphysema and has nothing to do with coal workers' pneumoconiosis and that he could have a coal workers' bronchiolitis which is adding to those radiographic abnormalities.
>
> So not all of the abnormalities seen radiographically are the result of coal workers' pneumoconiosis. Some of it is due to smoking.
>
> Overall, there is a mild pulmonary impairment which in my opinion was of no significance. I think his smoking habit of one to one-half pack of cigarettes per day for most of his life was responsible for the bulla present radiographically and the large portion responsible for the airway obstruction that may be present and

was hinted at by the lung volumes and by the breathing test performed in the year 2000.

(EX 28, p.8).

Dr. Zaldivar characterized Mr. Smith's coal mine job as heavy labor. (EX 28, p.10). Based on his exercise blood gas, Dr. Zaldivar concluded that Mr. Smith could return to his previous coal mine job.

Dr. Zaldivar reviewed the medical records from Dr. Bellam's treatment of the claimant. Dr. Bellam prescribed nebulizers for the Claimant. Dr. Zaldivar testified that none of the medications prescribed to Claimant would help with coal workers' pneumoconiosis. He explained: "[c]oal workers' pneumoconiosis causes an anatomical damage by causing mechanical obstruction of the airways and possible destruction of the airways distal to the mechanical damage. There is no inflammation, so these medications would not do any good for coal workers' pneumoconiosis." (EX 28, pp.10-11).

Dr. Zaldivar testified that the pulmonary function study performed by Dr. Baker is valid. From Dr. Baker's results, Dr. Zaldivar conclude that there is an obstruction present. He further stated that although the breathing test is abnormal, it does not mean Mr. Smith could not go back to work. Relying on his exercise test in 2003, Dr. Zaldivar stated that Dr. Baker's results do not change his opinion that the claimant could return to his previous coal mine job. (EX 28, pp.15-17).

Dr. Zaldivar concludes that Claimant has pneumoconiosis, however, he also believes that cessation of smoking would clear some of the densities found on Mr. Smith's X-rays. In regards to Mr. Smith's impairment, Dr. Zaldivar stated "I cannot exclude coal workers' pneumoconiosis as causing some of the impairment. All I can say is that over the years, if smoking has been found to be a more potent inducer of airway obstruction emphysema than mining." (EX 28, p.21).

Dr. Glen Baker is a B reader and Board-certified in internal medicine and pulmonary diseases. He examined the Claimant on October 19, 2002. His examination report notes 22 years of coal mine employment, all underground except for 1-2 years of surface work. Dr. Baker described the claimant's medical history as pneumonia in 1964, attacks of wheezing and chronic bronchitis manifesting 8-10 years ago, and an allergy to bee stings. Dr. Baker noted that the Claimant is a current smoker who began smoking one pack per day at age 18. Dr. Baker listed Claimant's symptoms as sputum, wheezing, dyspnea, and cough, all daily for the past 8-10 years. Claimant complained of shortness of breath at night. Claimant's symptoms have been helped with a nebulizer. (CX 1).

Dr. Baker diagnosed coal workers' pneumoconiosis, COPD with moderate obstructive defect, chronic bronchitis, and Hypoxemia. His diagnosis of coal workers' pneumoconiosis is based on an abnormal chest X-ray and coal dust exposure. He opined that the claimant's pulmonary condition was related to his coal dust exposure and cigarette consumption. Dr. Baker concluded that Claimant has a moderate degree of impairment. He also stated, however, that the

Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. (CX 1).

Dr. Baker submitted a letter responding to objections by Dr. Renn, dated September 12, 2003. Dr. Baker is of the opinion that the results he obtained would be representative of claimant's pulmonary function on a day-to-day basis. Dr. Baker explained that Mr. Smith had bilateral inspiratory and expiratory wheezing. He explained that this would make it difficult for Mr. Smith to perform the tests and have traces look as good as normal. Dr. Baker maintains his conclusion that Mr. Smith has a degree of obstructive airway disease related to his coal dust exposure. Dr. Baker stated that the values obtained during testing, associated with his wheezing, would imply that Mr. Smith is 100% occupationally disabled for further work in any type of dusty environment that would be calculated to worsen his condition. (CX 1).

Dr. Kirk Hippensteel, who is a B-reader and Board-certified in internal medicine with a subspecialty in pulmonary disease, submitted a consultation report, based on his review of the Claimant's medical records, dated May 21, 2002. Dr. Hippensteel reiterated the work and smoking history noted in the medical records. Dr. Hippensteel concluded that the evidence is "strongly against coal workers' pneumoconiosis," but is consistent with some progressive obstructive impairment due to his prolonged and continued cigarette smoking. Dr. Hippensteel also concluded that his impairment would not keep him from performing his last coal mine employment. (EX 18).

Dr. Hippensteel was deposed by the Employer, on May 29, 2002. Dr. Hippensteel discussed his May 21, 2002 report regarding Mr. Smith. He characterized Mr. Smith's smoking history as a heavy smoking history. (EX 19, p.11).

Dr. Hippensteel testified regarding Mr. Smith's radiographical evidence. He stated that there were few positive readings; most were classified as 0/0. Dr. Hippensteel explained that a 1/0 interpretation is marginally positive for pneumoconiosis. He noted that there are many other diseases of the lung that would result in a 1/0 profusion, including chronic bronchitis resulting from smoking. (EX 19, p.11). Dr. Binns found s and t type opacities on an X-ray reading. Dr. Hippensteel stated that findings of such irregular opacities as described by Dr. Binns are common among smokers. (EX 19, p.12).

Dr. Hippensteel opined that Dr. Ranavaya's May 30, 2000 ventilatory function study is invalid. He explained that only one value was obtained; thus, the test was insufficient to determine if Mr. Smith was consistent in his efforts. (EX 19, p.13). Dr. Hippensteel found the pulmonary function study performed by Dr. Zaldivar valid. He also found, however, that Dr. Zaldivar interpreted the study as showing moderate irreversible obstruction. Dr. Hippensteel determined the results show no higher than a very mild obstruction. (EX 19, p.14). Dr. Hippensteel also disagreed with Dr. Zaldivar's interpretation of the diffusion capacity study. Dr. Zaldivar found a moderate diffusion impairment. Dr. Hippensteel found no more than a very mild impairment. (EX 19, pp.15-16).

Dr. Hippensteel discussed the arterial blood gases performed by Dr. Ranavaya and Dr. Zaldivar. Dr. Hippensteel disagreed with the barometric pressure listed by Dr. Ranavaya. If the barometric pressure determined by Dr. Hippensteel is correct, the results change from a

qualifying to a non-qualifying blood gas. (EX 19, pp.17-18). Dr. Hippensteel interpreted the results of Dr. Zaldivar's study to show a normal gas exchange. (EX 19, p.19).

Based on the pulmonary function studies and arterial blood gases, Dr. Hippensteel concluded that Mr. Smith did not show enough permanent impairment to prevent him from performing his last coal mine employment. He concluded that the Claimant's cigarette smoking was the "most likely cause for his obstructive lung disease." (EX 19, p.20).

Dr. Hippensteel was questioned on why he determined that Mr. Smith's impairment is related to cigarette smoking as opposed to his coal mine dust exposure. He answered:

> [C]igarette smoking is a potent producer of obstructive airways disease. It is a producer of airways disease that is variable from one time to the next during the course of one's habit. It is a disease that has either minor or no radiographic deposition associated with it, like coal workers' pneumoconiosis usually does.
>
> It is a disease that can affect gas exchange just like coal workers' pneumoconiosis, so in separating out when one ascribes to the disease, related cigarette smoking versus coal workers' pneumoconiosis, one uses all of the circumstances that are likely to be present in one set of causative factors as versus another set, and this circumstance is looking at those factors of his coal mine dust exposure, which was much more minor than his cigarette smoke exposure, and these other factors related to his findings on examinations, and these findings put together make it so that one can state with a reasonable degree of medical certainty that this fits into a category of cigarette induced disease rather than coal mine dust-induced disease.

(EX 19, pp.24-25). Dr. Hippensteel concluded that Mr. Smith does not have medical or legal pneumoconiosis.

Dr. Hippensteel submitted a second consultation report, dated June 26, 2003. Dr. Hippensteel stated "[t]he additional records reviewed raise some question about cause of new abnormalities on his chest X-ray, which have appeared essentially in the last two years, which would not be typical for progression rate of simple coal workers' pneumoconiosis." Dr. Hippensteel did not find enough pulmonary impairment to keep him from working at his prior job in the coal mines. After review of additional medical records, Dr. Hippensteel affirmed that his conclusions noted in his May 21, 2002 report and May 29, 2002 deposition remain valid. (EX 23).

On June 28, 2004, Dr. Hippensteel submitted a supplemental report after reviewing Dr. Bellam's medical records.[16] Dr. Hippensteel concluded that the pulmonary function study performed by Dr. Bellam is invalid because only one effort was obtained. Dr. Hippensteel asserted that the additional evidence does not alter his conclusion that Mr. Smith does not have coal workers' pneumoconiosis or a sufficient pulmonary impairment. (EX 27).

[16] The portion of Dr. Hippensteel's opinion referring to matters other than Dr. Bellam's treatment records and his previous reports is excluded from the record and not considered. (TR 21-22).

Dr. Rosenberg, who is a B-reader and Board-certified in internal medicine, pulmonary disease and occupational medicine, submitted a consultation report, based on his review of the claimant's medical records, dated November 13, 2001. His consultation report notes 18 years of coal mine employment. Dr. Rosenberg reiterated the smoking history noted in the medical reports. He described the Claimant's symptoms as shortness of breath, coughing, wheezing and sputum production. Based on the X-rays and pulmonary function studies, Dr. Rosenberg concluded that Mr. Smith does not have the interstitial form of coal workers' pneumoconiosis. (EX 12).

From a physiologic perspective, Dr. Rosenberg found a mild-moderate degree of obstruction in Mr. Smith's lungs. He explained that the airflow obstruction is associated with air trapping found on his pulmonary function tests. Dr. Rosenberg concluded that Mr. Smith is not disabled, and could perform his previous coal employment. He noted that any impairment Mr. smith has is related to his extensive smoking history. He further stated that any chronic lung disease found in Mr. Smith is not related to coal dust exposure. (EX 12).

Dr. Rosenberg reviewed additional medical records and submitted a second consultation report, dated June 25, 2003. Dr. Rosenberg stated that "the new data indicates that there is persistence of some airflow obstruction with improvement after bronchodilators, and Mr. Smith has continued to smoke, although on the most recent evaluation he was stated to have stopped the day before." (EX 24).

Dr. Rosenberg agreed with Dr. Zaldivar that the X-ray findings could be related to smoking-related interstitial lung disease and a respiratory bronchiolitis. He stated "[o]bviously, while CWP can be latent in development, it still would be unusual that Mr. Smith would develop simple CWP many years having been removed form the coal mine industry." (EX 24).

Dr. Rosenberg also noted that Mr. Smith has a degree of airflow obstruction with some reversibility, along with a borderline low diffusing capacity and elevated carboxyhemoglobin level. Dr. Rosenberg does not doubt that Mr. Smith's long smoking history caused the obstructive lung disease to develop. Dr. Rosenberg did not find Mr. Smith disabled. (EX 24).

On June 30, 2004, Dr. Rosenberg submitted a supplemental report after reviewing Dr. Bellam's medical records.[17] Dr. Rosenberg concluded that the pulmonary function study performed by Dr. Bellam is not valid because reproducibility data were not available. Dr. Rosenberg concluded that Mr. Smith does not have coal workers' pneumoconiosis. He explained that Mr. Smith's airflow obstruction is related to his long smoking history. He further concluded that Mr. Smith is not disabled from a pulmonary perspective. (EX 27).

Dr. James R. Castle is a B-reader and is Board-certified in internal medicine and pulmonary disease. He prepared a consultation report, based upon his review of the medical records of the claimant, dated May 17, 2001. Dr. Castle reiterated the work history and smoking history noted in the records. (EX 5). Dr. Castle described the claimant's symptoms as shortness of breath, productive cough, and tires easily. After review of the medical records, Dr. Castle concluded "[i]t is my opinion with a reasonable degree of medical certainty based on a thorough

[17] The portion of Dr. Rosenberg's opinion referring to matters other than Dr. Bellam's treatment records and his previous reports is excluded from the record and not considered. (TR 21-22).

review of all the data including medical histories, physical examinations, radiographic reports, physiologic testing, and arterial blood gases as well as other data that Mr. Ronnie Smith does not suffer from coal workers' pneumoconiosis." (EX 5).

Dr. Castle stated that Mr. Smith worked in the coal mining industry for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. He also termed Mr. Smith's smoking history as a very extensive smoking history. He stated that he smoked more than one pack per day for at least 40 years. He noted that such a smoking history is sufficient enough to have caused him to develop chronic obstructive pulmonary disease in a susceptible host. (EX 5).

Dr. Castle remarked that Mr. Smith did not demonstrate any consistent findings indicating the presence of an interstitial pulmonary process. Dr. Castle mentioned that the physiologic studies showed evidence of a moderate degree of airway obstruction without restriction. Dr. Castle opined that his impairment is due to "his long and extensive tobacco smoking history" and not related to his coal dust exposure. Dr. Castle concluded that Mr. Smith retains the respiratory capacity to perform his usual coal mine employment. (EX 5).

On July 23, 2001, Dr. Castle was deposed by Employer's counsel. (EX 9). Prior to the deposition, Dr. Castle reviewed his own report and the May 16, 2001 report by Dr. Loudon. He also reviewed reports regarding the November 18, 1994 and May 30, 2000 X-rays. (EX 9, pp. 9-10).

Dr. Castle read a November 29, 2000 X-ray taken in conjunction with Dr. Zaldivar's examination. Dr. Castle classified the film as q/q, 0/1. He stated that "there are a few opacities there but not of enough profusion to make it positive." He also found a 1 ½ cm nodule over the 8th posterior rib. He stated, however, that the nodule is not related to pneumoconiosis in any way. (EX 9, p.11).

Dr. Castle testified that the pulmonary function study performed by Dr. Ranavaya, dated May 30, 2000, is not a valid study. Dr. Castle explained "[h]e did a single spirometric test which I thought was invalid because of less than maximal effort and inadequate exhalation time." (EX 9, p.14).

Dr. Castle determined the pulmonary function study performed by Dr. Zaldivar valid. Dr. Castle was questioned on the reversibility found in Dr. Zaldivar's results. The pre-bronchodilator result was 74 percent of predicted and the post-bronchodilator result was 80 percent of predicted. Dr. Castle did not view this as a true reversibility. He explained that the claimant could have exhaled longer during the pre-bronchodilator study and, thus, the effort could be related to the results. Dr. Castle believes that Mr. Smith gave more effort during the post-bronchodilator study, than the pre-bronchodilator study. (EX 9, p.17).

Dr. Castle discussed the results of arterial blood gas studies. He explained the increase in PO2 found in Dr. Ranavaya's study as inconsistent with coal workers' pneumoconiosis. "He did not have an abnormality of blood gas transfer mechanisms that you would see with coal workers' pneumoconiosis because he improved with exercise." (EX 9, p. 19). He explained that coal

workers' pneumoconiosis causes hypoxemia, which would result in a fall in the PO2 with exercise.

Dr. Castle opined that from a pulmonary standpoint, Mr. Smith could return to his usual coal mine employment. (EX 9, p.19). Dr. Castle also concluded the Mr. Smith does not have legal or medical coal workers' pneumoconiosis. (EX 9, p.21). He found that Mr. Smith has a respiratory impairment due to his excessive smoking history.

On July 7, 2003, Dr. Castle was deposed a second time by employer's counsel. (EX 25). In preparation for the deposition, Dr. Castle reviewed the medical records submitted since his July 23, 2001 deposition. (EX 25, p.10).

Dr. Castle noted that Claimant has a smoking history in excess of 40 years, with "perhaps as much as a 60-pack-year smoking history." A carboxyhemoglobin level was obtained at Dr. Zaldivar's April 23, 2003 examination. The results indicated that Mr. Smith was still being exposed to cigarette smoke at that time. Dr. Castle testified that such a smoking history is sufficient to cause significant cardiac and lung problems in a susceptible individual. (EX 25, pp.13-14). Dr. Castle noted 21 years of coal mine employment, according to Dr. Zaldivar's report. Dr. Castle classified Mr. Smith's coal mine employment as strenuous manual labor. (EX 25, p.14).

Dr. Castle discussed the chest X-ray taken during Dr. Zaldivar's April 23, 2003 examination. He testified that the film is definitely abnormal. He explained that the changes in the right mid-lung zone are irregular type changes. He also stated that here are still a few rounded opacities of the q variety, which were seen on the 2000 X-ray reviewed by Dr. Castle. Dr. Castle interpreted the April 23, 2003 X-ray as 1/1. However, he doesn't believe that the changes are due to pneumoconiosis. His reasons for not finding pneumoconiosis is that the changes took place years after coal mine dust exposure ceased and the opacities are of an irregular type. (EX 25, pp.17-18).

Dr. Castle testified regarding the pulmonary functions studies performed on Mr. Smith. Dr. Castle found Dr. Baker's October 19, 2002 study invalid. Dr. Castle stated "I don't find this to be a valid study, based on the fact that there is hesitation at the onset of exhalation which artificially reduces the FEV1, as well as the lack of maximum effort throughout the rest of the study." (EX 25, p.20). Dr. Castle testified that pulmonary function studies require a maximum effort in order to obtain useful physiologic data.

Dr. Castle also concluded that Dr. Zaldivar's April 23, 2003 pulmonary function study is invalid. The spirometry of this test was invalid due to poor effort. Dr. Zaldivar also agreed the study is invalid. (EX 25, p.24).

Dr. Castle discussed the arterial blood gas results. He concluded that the arterial blood gas taken by Dr. Baker showed normal results and did not represent hypoxemia. He also found that Dr. Zaldivar's resting and exercise results were normal. (EX 25, pp.28-29).

After review of the evidence. Dr. Castle concluded Mr. Smith "has evidence of a mild degree of airway obstruction, without restriction, associated with radiographic changes of bullous emphysema that in my opinion is related to his very long and extensive tobacco smoking

habit." He does not have pneumoconiosis or a disabling abnormality of ventilatory function. Dr. Castle concluded that Mr. Smith does not have legal or medical pneumoconiosis. (EX 25, p.3).

On June 25, 2004, Dr. Castle submitted a supplemental report.[18] Dr. Castle reviewed the medical records from Dr. Bellam. Dr. Bellam concluded that Mr. Smith has coal workers' pneumoconiosis. (EX 27). Dr. Castle opined that Dr. Bellam's pulmonary function study of the Claimant is invalid. He stated that it is invalid because only one forced vital capacity maneuver was obtained both pre and post bronchodilator. (EX 27). Dr. Castle asserted that nothing in Dr. Bellam's medical records alters his previous conclusion that Mr. Smith does not have coal workers' pneumoconiosis or a disabling respiratory impairment. (EX 27).

Dr. Ranavaya, a B-reader, submitted an examination report, based on his medical examination of the Claimant, dated May 30, 2000. Dr. Ranavaya noted 18 years of coal mine employment, with 16 of those years underground. Dr. Ranavaya noted that the Claimant is a current smoker, who began smoking in 1959, at 1 ½ packs per day. (DX 12).

Dr. Ranavaya listed the Claimant's symptoms as: sputum, wheezing, dyspnea, cough, hemoptysis, chest pain and paroxysmal nocturnal dyspnea. He also stated that Mr. Smith complains of shortness of breath upon mild to moderate exertion. He becomes short of breath when walking 100 yards on level ground, 5-10 feet up a gentle incline and up 10 steps. At the time of the examination, Mr. Smith was being treated with two inhalers. (DX 12).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed coal workers' pneumoconiosis. Dr. Ranavaya found a mild pulmonary impairment, caused by the pneumoconiosis, which in and of itself would not prevent Mr. Smith from performing his usual or last coal mine employment. (DX 12).

III. Physician Office Notes

Dr. Bellam is Board-certified in emergency medicine and family practice. (CX 20). He treated Claimant at a West Virginia Black Lung Clinic. The Claimant's first visit was on September 26, 2001. Claimant had a follow-up appointment every 90 days, with the last visit dated March 4, 2004. Claimant complained of coughing, wheezing, and shortness of breath. On October 23, 2001, Dr. Bellam diagnosed coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Bellam advised claimant to use the drug Atrovent to alleviate symptoms. At a follow-up appointment, on January 15, 2002, Claimant stated that the Atrovent seemed to cause him more problems, than it helped him. Dr. Bellam discontinued the Atrovent treatment. (CX 13).

During his treatment at the clinic, an X-ray was taken and a pulmonary function study performed. Dr. Iko read the X-ray, dated October 7, 2001. Dr. Iko concluded the X-ray showed chronic interstitial lung disease, compatible with coal workers' pneumoconiosis. The pulmonary function study, dated October 5, 2001, produced an FVC of 3.43 and an FEV1 of 1.72. (CX 13).

IV. Claimant's Testimony

[18] The portion of Dr. Castle's opinion referring to matters other than Dr. Bellam's treatment records and his previous reports is excluded from the record and not considered. (TR 21-22).

Ronnie Smith testified at the hearing on July 1, 2004. (TR 6). He was 63 years old on the date of the hearing. Mr. Smith stated that his last job in the mines was that of a shuttle-car operator. He also worked as a welder and a mechanic at the mine. He testified that his position required him to lift up to 100 pounds. (TR 7-8).

Mr. Smith ceased working in the mines in 1996, when he was laid off. Mr. Smith testified that he was having breathing problems when he left the mine. He filed for social security benefits due to his lung problems and was awarded such benefits. (TR 9).

Mr. Smith stated that he is currently smoking between a half a pack to a pack of cigarettes per day. He started smoking at age 19. He explained that the amount he smokes per day has fluctuated throughout his lifetime from a half a pack to three packs per day. (TR 9-10).

Mr. Smith explained that he has difficulty lifting items. He stated that he can lift about 5-10 pounds at the most for about 20 feet before needing a break. He stated that he has difficulty lifting his grandson, who weighs about 40 pounds. (TR 11). Mr. Smith testified that he carries a nebulizer and uses it, on average, four times a day. (TR 12).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986).

Since this is the claimant's second claim for benefits, and it was filed before January 19, 2001, under the old regulations, he must initially show that there has been a material change of conditions.[19]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of January 18, 1995, i.e.,

[19] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part…[i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions…
> (Emphasis added).

pneumoconiosis and disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale,* the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's first application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 25). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[20]

[20] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers'

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[21] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[22] 20 C.F.R. § 718.202(a)(4).

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pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[21] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[22] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented"

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

The April 23, 2003 X-ray, read by eleven doctors, is the most recent X-ray in evidence. Five dually qualified physicians read this X-ray as negative for pneumoconiosis. Four dually qualified readers and two B-readers read the X-ray as positive for pneumoconiosis. Although more doctors have read the April 23, 2003 X-ray as positive for pneumoconiosis, after weighing the qualifications of the doctors, I find the April 23, 2003 X-ray neither precludes nor establishes the presence of pneumoconiosis.

Dr. Baker included an October 19, 2002 positive X-ray reading in his examination report. The October 19, 2002 X-ray film was later lost and, as such, no other readings of this X-ray are included in evidence.[23] As the only reading of this X-ray is positive, I find the October 19, 2002 X-ray positive for pneumoconiosis.

The October 7, 2001 X-ray was only read by Dr. Iko and was included as part of Dr. Bellam's treatment records. Dr. Iko's qualifications are not in the record. Dr. Iko stated that the X-ray shows chronic interstitial lung disease, compatible with coal workers' pneumoconiosis.

(medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[23] As noted in footnote 2, the October 19, 2002 X-ray reading included in Claimant's exhibit 2 was stricken from the record. Dr. Baker's reading, taken during his examination of the Claimant, is part of Claimant's exhibit 1. This reading has not been stricken from the record as part of the August 30, 2004 Order.

Dr. Iko, however, does not include a category profusion. Under 20 C.F.R. § 718.102(b) the minimum interpretation that qualifies as positive for the presence of pneumoconiosis is 1/0. If no categories are stated, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis. As Dr. Iko did not provide a category profusion, I find that the October 7, 2001 X-ray does not establish the presence of pneumoconiosis.

Six doctors read the November 29, 2000 X-ray. Five doctors determined that the X-ray does not show evidence of pneumoconiosis. Dr. Zaldivar interpreted the X-ray as a 1/1 category profusion. Thus, I find the November 29, 2000 X-ray is negative for pneumoconiosis.

There are 14 readings of the May 30, 2000 X-ray in evidence. Six dually qualified physicians and one B-reader interpreted the X-ray as negative for pneumoconiosis. Five dually qualified physicians and two B-readers interpreted the X-ray as positive for pneumoconiosis. Based on 7 positive and 7 negative readings by physicians experienced in interpreting X-rays for coal workers' pneumoconiosis, I find the May 30, 2000 X-ray neither establishes nor precludes the existence of pneumoconiosis.

The November 18, 1994 X-ray was interpreted by six doctors as negative for pneumoconiosis. Thus, I find that the November 18, 1994 X-ray does not establish the presence of pneumoconiosis.

In summary, I find two X-rays negative, one positive, one not properly classified, and two in equipoise.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[24] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of

[24] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Baker, Castle, Hippensteel, Rosenberg and Zaldivar above Drs. Bellam, Loudon and Ranavaya.

Dr. Baker concluded that Mr. Smith has CWP, COPD with moderate obstructive defect, chronic bronchitis and hypoxemia. He listed coal dust exposure as the cause of all four of the above listed cardiopulmonary diagnosises. Dr. Baker also listed cigarette smoking as a cause of Claimant's COPD, chronic bronchitis and hypoxemia. In responding to a questionnaire, Dr. Baker noted that the basis of his diagnosis is an abnormal chest X-ray and coal dust exposure. Dr. Baker merely listed Claimant's symptoms and his diagnoses. As Dr. Baker did not provide a detailed explanation of how Claimant's symptoms related to the diagnosis of pneumoconiosis, I find that Dr. Baker's opinion regarding the existence of pneumoconiosis is entitled to little weight.

Dr. Castle reviewed the medical records and determined that Claimant does not have legal or medical pneumoconiosis. He stated that Mr. Smith does not have the physical findings, radiographic findings or physiologic findings necessary to find the presence of CWP. Dr. Castle testified at a deposition that Mr. Smith's respiratory impairment is due to his extensive smoking history. Dr. Castle discussed the April 23, 2003 X-ray included in Dr. Zaldivar's examination report. Dr. Castle concluded that the April 23, 2003 film is definitely abnormal. He stated, however, that he does not believe the changes since prior X-rays are due to pneumoconiosis. He stated two reasons for this conclusion: (1) the increased opacities are primarily irregular type opacities and (2) it is not possible to see that big a change due to pneumoconiosis in a 2 ½ year period, particularly with the exposure to coal mine dust having ceased. Dr. Castle stated that the X-ray also shows tobacco smoke-induced bullous emphysema. Based on Dr. Castle's detailed explanation of his conclusion, I find that Dr. Castle's opinion is entitled to more weight than Dr. Baker's opinion.

Dr. Hippensteel concluded that Claimant's evidence is consistent with a progressive obstructive impairment due to cigarette smoking. He concluded the claimant does not have CWP. Dr. Hippensteel stated that the radiographic evidence found to establish CWP could actually be a result of chronic bronchitis related to smoking. He further stated that the irregular opacities found are common among smokers. Dr. Hippensteel noted in his June 26, 2003 report that the X-ray changes seen in Claimant's evidence from 2001 to 2003 is not the typical progression rate of simple CWP. As noted above, this is consistent with Dr. Castle's findings. Based on his thorough explanation of Claimant's X-ray evidence, I find that Dr. Hippensteel's opinion is entitled to more weight than Dr. Baker's opinion.

Dr. Rosenberg concluded the Claimant does not have coal workers' pneumoconiosis. Dr. Rosenberg found that Claimant's obstructive lung disease is caused by his smoking history. He explained that Claimant's obstructive impairment correlates with the chest X-ray findings of emphysema. Dr. Rosenberg reviewed the most recent chest X-ray evidence. He stated that while coal workers' pneumoconiosis can be latent in development, it would be unusual for Mr. Smith to develop simple coal workers' pneumoconiosis after many years of no coal dust exposure. I find that Dr. Rosenberg provided a thorough evaluation of the Claimant's medical evidence. His findings were consistent with the evidence of record. Thus, I find that Dr. Rosenberg's opinion is entitled to more weight than Dr. Baker's opinion.

After Dr. Zaldivar's first examination of the Claimant, he concluded that Claimant has coal workers' pneumoconiosis. He also concluded that a major part of Claimant's impairment is due to smoking related emphysema. During his deposition, Dr. Zaldivar testified that Mr. Smith's physical examination exhibited no abnormalities specifically attributable to coal workers' pneumoconiosis. He also stated that Claimant's pulmonary function study results show an obstruction consistent with emphysema. Dr. Zaldivar stated that Claimant's cigarette smoking "pretty much caused all of his emphysema." (EX 8, p.9). Dr. Zaldivar stated that Claimant's emphysema is also visible radiographically. He testified that Claimant has a small amount of dust in his lungs. He explained that this amount of dust could be read by some physicians as 0/1 and others as 1/0.

After Dr. Zaldivar's second examination of the Claimant, he concluded that Claimant's X-ray showed bullae scattered throughout the lungs resulting from emphysema. His conclusion is equivocal. Dr. Zaldivar stated that the X-ray shows abnormalities which resemble pneumoconiosis, but may be due to smoker's bronchitis. Dr. Zaldivar testified at a second deposition that both his 2000 and 2003 examinations of the Claimant resulted in radiographic evidence of coal workers' pneumoconiosis. When discussing Claimant's pulmonary impairment, Dr. Zaldivar stated claimant radiographically appears to have coal workers' pneumoconiosis and bullae that "has something to do with coal workers' emphysema." At his first deposition, Dr. Zaldivar related Claimant's emphysema to cigarette smoking, not coal dust exposure. Dr. Zaldivar is not clear on whether Claimant's emphysema is caused by cigarette smoking or coal dust exposure or both. Furthermore, Dr. Zaldivar diagnosed coal workers' pneumoconiosis, but also states that a CT scan would be helpful in determining whether Claimant has pneumoconiosis or not. I find that Dr. Zaldivar's opinion is equivocal. Thus, I give less weight to Dr. Zaldivar's opinion than the opinions of Drs. Castle, Hippensteel and Rosenberg.

Dr. Loudon submitted two consultation reports and provided a thorough review of Claimant's medical evidence. He concluded that Claimant has a smoking induced pulmonary impairment. Dr. Loudon concluded that there was insufficient objective evidence to diagnose coal workers' pneumoconiosis. Dr. Loudon provided an accurate summary of the evidence. He did not, however, explain how the Claimant's medical evidence led him to conclude that Claimant does not have coal workers' pneumoconiosis. Dr. Loudon summarized the evidence and numerically listed his conclusions. In his first report, he did list a summary of the X-ray evidence with his diagnosis that Claimant does not have coal workers' pneumoconiosis. Aside from that, in both reports, he did not relate specific symptoms or test results to his conclusions. Thus, I find that his opinion is not as detailed and reasoned as the opinions of Drs. Castle, Hippensteel and Rosenberg. Thus, I give more weight to the opinions of Drs. Castle, Hippensteel and Rosenberg than Dr. Loudon's opinion.

Dr. Ranavaya performed Mr. Smith's Department of Labor examination. He diagnosed coal workers' pneumoconiosis based on 18 years of coal mine employment and radiographic evidence of coal workers' pneumoconiosis. Dr. Ranavaya does not provide any further detail of how he concluded claimant has coal workers' pneumoconiosis. Furthermore, Dr. Ranavaya correctly notes Claimant's smoking history, however, when listing his diagnosis he makes no mention of the effect, if any, of Claimant's extensive smoking history on his pulmonary impairment. All the other doctors of record concluded that Claimant's smoking history

contributed in some way to his pulmonary impairment. Thus, I give more weight to the opinions of Drs. Castle, Hippensteel and Rosenberg than Dr. Ranavaya's opinion.

While the courts and the Board earlier recognized that there may be a practical distinction between a physician who merely examines a miner and one who is one of his "treating" physicians, that preference has largely been obviated.[25] In *Black and Decker Disability Plan v. Nord,* Case No. 02-469, ___ U.S. ___, ___ S.Ct. ___ (May 27, 2003), the Court held ERISA plan administrators (Courts) need not give special deference to the opinion of a treating physician. Dr. Bellam treated Mr. Smith at a West Virginia Black Lung Clinic from September 2001 through March 2004. As such, his opinion must be considered under the criteria of section 718.104(d).[26]

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[25] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994). *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for Judge to accord greater weight to treating physician over non-examining doctors). *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co*., 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians), "a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)." *But see, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin,* 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.3d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989). *Consolidation Coal Co. v. Director, OWCP [Held]*, ___ F.3d ___, Case No. 99-2507 (4th Cir. Dec. 20, 2000)(with Dissent). Improper to accord greater weight to the opinion of treating physician because he had treated and examined claimant each year over the past ten years. In *Grizzle v. Pickland Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993), we clearly stated we had not fashioned any presumption or requirement that the treating physicians' opinions be given greater weight. While the treating physician's opinion here may have been entitled to "special consideration", it was not entitled to the greater weight accorded. In *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), the Court made clear its view that no deference is given to treating physicians merely because of their status as the same. It pointed out, citing Black & Decker Disability Plan v. Nord, 123 S.Ct. at 1969, 1971, the Supreme Court itself has "disapproved of the 'treating physician rule' with language that criticizes the principle itself, rather than its operation in an ERISA context."

[26] § 718.104(d) Treating Physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

Mr. Smith had follow-up appointments approximately every 90 days with Dr. Bellam for almost three years. Dr. Bellam is a physician with a black lung clinic. His treatment of Claimant related solely to Claimant's pulmonary problem. Dr. Bellam diagnosed Claimant with coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Bellam noted Claimant's smoking history, but he makes no mention of his smoking history causing any of Claimant's impairment. Dr. Bellam's records provide no explanation for his diagnosis of coal workers' pneumoconiosis. He notes Claimant's symptoms, but does not state why such symptoms led him to conclude Claimant has coal workers' pneumoconiosis. Dr. Bellam's treatment records and the duration of his doctor/patient relationship with Claimant provide no special insight into Claimant's pulmonary condition warranting special consideration of his conclusion.

In summary, I find that the opinions of Drs. Castle, Hippensteel and Rosenberg are entitled to the most weight. Drs. Castle, Hippensteel and Rosenberg are highly qualified doctors who provided thorough and reasoned opinions concluding that Claimant does not have coal workers' pneumoconiosis. I find that the opinions of Drs. Baker, Loudon and Ranavaya are entitled to less weight than the opinions of Drs. Castle, Hippensteel and Rosenberg. As discussed above, Drs. Baker, Loudon and Ranavaya did not provide as thorough and detailed explanation of their findings as was provided by Drs. Castle, Hippensteel and Rosenberg. I find that Dr. Zaldivar's opinion is equivocal and, as such, entitled to less weight than the other opinions of record. Additionally, I find that Dr. Bellam's treatment records do not warrant special consideration as a treating physician. Furthermore, I find that Dr. Bellam did not provide a detailed and thorough rationale in his treatment records for his conclusion that Claimant has pneumoconiosis.

After reviewing the X-ray evidence and physician reports together, I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the

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(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[27] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718.

Eight pulmonary function studies were performed, five pre-bronchodilator studies and three post-bronchodilator studies. Six of the studies resulted in qualifying results.

Dr. Zaldivar's April 23, 2003 post-bronchodilator study produced a qualifying result. However, Dr. Zaldivar noted an invalid spirometry due to poor effort. As noted above, Dr. Castle also concluded that Dr. Zaldivar's April 23, 2003 pulmonary function study is invalid.

[27] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. Fro purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

Dr. Baker's October 19, 2002 pre-bronchodilator study produced a qualifying result. Drs. Renn and Castle determined this study invalid. Dr. Zaldivar, however, determined that the pulmonary function study is valid.

Included in Dr. Bellam's treatment records are a pre-bronchodilator and a post-bronchodilator qualifying study. Drs. Hippensteel and Castle found this study invalid because only one effort was obtained. Dr. Rosenberg stated that the study is not valid because reproducibility data was not available.

A November 29, 2000 post-bronchodilator test by Dr. Zaldivar produced qualifying results. The pre-bronchodilator test on this date did not produce a qualifying result. Dr. Hippensteel found this study valid, but interpreted the study as illustrating a very mild obstruction. Dr. Castle also determined this study valid.

Dr. Ranavaya's May 30, 2000 pre-bronchodilator study produced a qualifying result. Drs. Dahhan, Renn, Gaziano, Castle and Hippensteel concluded the study is invalid.

Although a majority of the pulmonary function studies produced qualifying results, I find that the claimant did not prove total disability based on pulmonary function studies, due to the numerous physician opinions concluding that most of the qualifying studies are invalid. Whereas, the validity of the remainder is in equipoise.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. §718.204(b)(2)(ii).

The record contains seven arterial blood gas studies. The only qualifying study is the May 30, 2000 pre-exercise study performed by Dr. Ranavaya. Thus, I find the Claimant did not prove total disability based on arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As summarized above, the record contains physician opinions by Drs. Baker, Bellam, Castle, Hippensteel, Loudon, Ranavaya, Rosenberg and Zaldivar. The only doctor to state that

Mr. Smith is totally disabled is Dr. Baker. Dr. Baker concluded that Mr. Smith has a moderate degree of impairment. He goes on to state that Mr. Smith is 100% occupationally disabled for further work in any type of dusty environment that would be calculated to worsen his condition. Dr. Bellam's treatment records included a qualifying pulmonary function study, determined by some doctors to be invalid, but he does not state any conclusions regarding level of impairment in his treatment notes. The remaining doctors found a mild to moderate impairment. Therefore, I find the Claimant did not prove total disability based on physician opinions.

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms do not render him unable to walk short distances or do some lifting, I find he is capable of performing his prior coal mine employment.

I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

Since I have found that the evidence of record fails to establish that Mr. Smith suffers from a total respiratory disability, I accordingly find that Mr. Smith failed to establish that he suffers from a total respiratory disability due to pneumoconiosis.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in condition has taken place since the previous denial. The claimant does not have pneumoconiosis, as defined by the Act and Regulations. The claimant is not totally disabled. Accordingly, he is not totally disabled due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER

It is ordered that the claim of RONNIE L. SMITH for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[28]

[28] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.

APPENDIX A

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 26	4/23/2003 6/25/2004	Dr. Spitz	B, BCR	1		No evidence of coal workers' pneumoconiosis.
EX 26	4/23/2003 5/10/2004	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. The lung fields are over-expanded, consistent with emphysema. There are a few blebs at both apices. There is an ill-defined oval density in the right second anterior interspace.
CX 9	4/23/2003 8/19/2003	Dr. Cappiello	B, BCR	1	2/2	Pneumoconiosis category q/t, 2/2. Changes of chronic obstructive pulmonary disease (em).
CX 12	4/23/2003 8/13/2003	Dr. Aycoth	B, BCR	1	2/1	Pneumoconiosis category 2/1, p/t. Grade A bilateral pleural thickening.
CX 11	4/23/2003 8/8/2003	Dr. Pathak	B	1	2/2	Simple pneumoconiosis category q/t, 2/2. Emphysema. Bullae.
CX 10	4/23/2003 8/6/2003	Dr. Ahmed	B, BCR	1	2/1	Simple pneumoconiosis category q/p, 2/1. Emphysema. Coalescence of small pneumoconiotic opacities.
CX 8	4/23/2003 7/29/2003	Dr. Miller	B, BCR	1	2/1	Findings consistent with pneumoconiosis, category t/p, profusion 2/1. Heart size upper limits normal. Chronic obstructive pulmonary disease. Coalescence of small pneumoconiotic opacities. Bilateral apical scarring.

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 22	4/23/2003 6/3/2003	Dr. Scott	B, BCR	2		Hyperinflation lungs: emphysema vs deep breath. Bullae right apex. Calcified granuloma lateral right upper lung.
EX 22	4/23/2003 6/3/2003	Dr. Scatarige	B, BCR	2		Hyperinflation lungs c/w emphysema or deep breath. Minimal R apical fibrosis and 1 cm R apical bulla. Minimal discord artelectosis LLL above L CPA.
EX 22	4/23/2003 6/2/2003	Dr. Wheeler	B, BCR	2		Well inflated lungs compatible with deep breath or emphysema with probable slightly decreased left upper lung markings favoring emphysema. Tiny bleb or thin curved scar upper right apex. Incomplete lower portion right CPA. No other abnormality.
EX 21	4/23/2003 5/21/2003	Dr. Zaldivar	B, BCI(P)	1	1/1	p/s. all zones.
CX 1	10/19/2002 10/19/2002	Dr. Baker	B, BCI, BCP	1	1/0	
CX 13	10/7/2001 10/7/2001	Dr. Iko	Qualifications not in the record.			(Included in Dr. Bellam's treatment records). Chronic interstitial lung disease, compatible with coal workers' pneumoconiosis. No acute disease.
EX 15	11/29/2000 11/26/2001	Dr. Spitz	B, BCR	2		No evidence of coal workers' pneumoconiosis. Emphysema. Old granulomatous disease at right apex.

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 16	11/29/2000 11/17/2001	Dr. Meyer	B, BCR	2		No radiographic evidence of coal workers' pneumoconiosis. Emphysema. Nodular opacity as described, likely nipple shadow.
EX 11	11/29/2000 10/22/2001	Dr. Wiot	B, BCR	2		No evidence of coal workers' pneumoconiosis. The lung fields are over-expanded, consistent with emphysema. There is right apical pleural disease.
EX 1	11/29/2000 1/8/2001	Dr. Wheeler	B, BCR	2		Hyperinflation lungs with probable subtle decreased upper lung markings compatible with emphysema/ check PFTs. 1.5 cm nodule right lower lung due to granuloma or tumor or possible asymmetrical nipple/repeat with nipple marker and 15 degree obliques. Possible few tiny scars in right apex and lateral subapical portion RUL from healed TB.
EX 1	11/29/2000 1/8/2001	Dr. Scott	B, BCR	2		1.5 cm mass right lower lung: cancer versus granuloma or hematoma. Advise CT, comparison with old films.
DX 23	11/29/2000 12/16/2000	Dr. Zaldivar	B, BCI(P)	1	1/1	
CX 7	5/30/2000 12/12/2002	Dr. Aycoth	B, BCR	1	2/2	Pneumoconiosis category 2/2, q/t.
CX 5	5/30/2000 11/25/2002	Dr. Ahmed	B, BCR	1	2/2	Simple pneumoconiosis category t/q, 2/2. Emphysema.
CX 4	5/30/2000 11/21/2002	Dr. Cappiello	B, BCR	1	2/1	Pneumoconiosis category p/q, 2/1. Chronic obstructive pulmonary

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						disease (em).
CX 6	5/30/2000 11/19/2002	Dr. Pathak	B	1	2/2	Simple pneumoconiosis category q/t, 2/2. Emphysema.
CX 3	5/30/2000 11/14/2002	Dr. Miller	B, BCR	2	1/2	Finding consistent with pneumoconiosis, category t/q, profusion 1/2. Chronic obstructive pulmonary disease (em). Bilateral apical scarring.
EX 7	5/30/2000 6/28/2001	Dr. Fino	B, BCI(P)	3 - Dark	0/0	There were no changes consistent with a coal mine dust associated occupational lung disease.
EX 2	5/30/2000 2/2/2001	Dr. Meyer	B, BCR	1		No radiographic evidence of coal workers' pneumoconiosis. Hyperinflation. Subtle right apical irregular pleural parenchymal density likely sequella or prior granulomatous disease/post-inflammatory.
EX 1	5/30/2000 12/27/2000	Dr. Wiot	B, BCR	2		No evidence of coal workers' pneumoconiosis. The lung fields are somewhat over-expanded, consistent with emphysema. There is minimal old granulomatous disease with pleural thickening at the right apex. This is not a manifestation of coal dust exposure.
DX 22	5/30/2000 12/14/2000	Dr. Kim	B, BCR	1		Hyperinflated lungs. Also suspect fibrosis in the right apex blebs.

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 21	5/30/2000 12/1/2000	Dr. Wheeler	B, BCR	1		Well inflated lungs compatible with good deep breath, but I can't rule out emphysema/calcified pleural plaque. Possible subtle fibrosis right apex from healed TB.
DX 21	5/30/2000 11/30/2000	Dr. Scott	B, BCR	2		Hyperinflation lungs: emphysema vs deep breath.
DX 15	5/30/2000 7/3/2000	Dr. Binns	B, BCR	2	1/0	
EX 2	5/30/2000 1/27/2000	Dr. Spitz	B, BCR	1		No evidence of coal workers' pneumoconiosis. Emphysema. Questionable nodular density just inferior to the aortic knob.
DX 16	5/30/2000 5/30/2000	Dr. Ranavaya	B	1	1/0	
EX 14	11/18/1994 11/29/2001	Dr. Kim	B, BCR	2		Hyperinflation lungs, suggestive of emphysema.
EX 13	11/18/1994 11/15/2001	Dr. Wheeler	B, BCR	2		Well inflated lungs compatible with deep breath or emphysema/ check PFTs. Possible few tiny calcified granulomata in lower lateral periphery RUL or pulmonary vascular prominence accentuated by underexposure. No silicosis or CWP.
EX 13	11/18/1994 11/14/2001	Dr. Scott	B, BCR	2		Hyperinflation lungs: emphysema versus deep breath.
EX 6	11/18/1994 6/5/2001	Dr. Perme	B	2	0/1	No definite radiographic evidence of coal workers' pneumoconiosis. In the mid lung zones bilaterally, there are a few questionable small poorly defined nodules of shape/size "q".

Ex. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 6	11/18/1994 5/11/2001	Dr. Spitz	B, BCR	1		No evidence of coal workers' pneumoconiosis. Probable old healed granulomatous disease at the right apex.
EX 4	11/18/1994 4/27/2001	Dr. Wiot	B, BCR	2		No evidence of coal workers' pneumoconiosis. The lung fields are over-expanded, consistent with emphysema. There are nipple shadows present bilaterally. There is pleural thickening at the right apex with minimal change consistent with old granulomatus disease.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.